STATE OF LOUISIANA

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING RATES - IN-PATIENT HOSPITAL CARE

CITATION
42 CFR
447.253
OBRA-90
P.L.
101-508
Sections
4702-4703
P.L.
102-234

Medical and Remedial
Care and Services
Item 1 (cont'd.)

e. The facility must maintain a log of indigent care services provided each fiscal year for audit purposes in compliance with state and federal rules and regulations. Patient identifying information such as patient name, social security number, date of birth, dates of service, medical record number, patient account number, number of free care days and amount of indigent care charges must be included on the log.

f. An indigent day may be included in the indigent care days count only to the extent that the entire day is deemed to be an indigent care day. If indigence is determined on a sliding scale which is based on total charges, any day for which the patient is liable for more than fifty (50%) per cent of the charges may not be considered as an indigent care day. Inpatient days denied for Medicaid recipients who had exhausted their Medicaid inpatient days may be recognized as indigent days provided that documentation of the reasons for denial demonstrates that the recipient is over the limit of days.

Medicaid days denied for other reasons resulting from failure to comply with Medicaid policies and procedures will not be recognized as indigent days. Prisoners receiving services in state hospitals are deemed indigent in accordance with Louisiana Revised Statutes 46:17. Inpatient days paid by Medicaid are not recognized as indigent days; nor are Hill-Burton days that are utilized to meet an obligation under this program recognized as free care days. Medicare bad debt days are not allowable as indigent days. Days for accounts written off as bad debt are not allowable as indigent days.

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42 CFR 447.253 OBRA-90 P.L. 101-508 Sections 4702-4703 P.L. 102-234	g. For state-operated facilities, an indigent care plan promulgated and implemented in accordance with DHH Policy 4600-77 shall be recognized in lieu of the above criteria for determining indigent care days eligible for disproportionate share payments. Items a. through e. above are not applicable to state-operated facilities. Indigent care days are counted as in f. above.

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Item 1 (cont'd.)

F. Distinct Part Psychiatric Units

Effective for services on or after January 1, 1989, psychiatric units within an acute care general hospital which meet the criteria for exemption from Medicare's Prospective Payment System (PPS) shall have admissions to this unit carved out and handled separately as a subprovider. A separate provider number shall be assigned to differentiate admissions to these units and their related costs from other hospital admissions and costs. Separate cost centers must be established as costs related to Distinct Part Psychiatric Unit admissions shall not be allowed in the cost settlement process applicable to other admissions. Rather, reimbursement for inpatient services provided in these units shall be a prospective statewide per diem rate.

Effective January 1, 1993, the statewide prospective per diem shall be recalculated using a base of reported 1991 allowable costs in accordance with Medicare principles of reimbursement. The rate is based on the statewide weighted average cost per day, using cost reporting periods ending in 1991 as a base period. Rates for subsequent years will be updated annually effective January 1 of each year by increasing the previous year's per diem rate by HCFA's target rate percentage for non-PPS (PPS Exempt) hospitals/units for the applicable year. The subsequent application of the inflationary adjustment shall apply only in years when the state legislature allocates funds for this purpose. The inflationary adjustment shall be made by applying the inflation factor applicable to the current fiscal year to the most recently paid per diem rate.

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Effective March 1, 1994, a unit in a PPS exempt hospital which meets PPS exempt psychiatric unit criteria as specified II.B.2. shall also be considered a Distinct Part Psychiatric Unit included in the methodology described above.

G. Transplant Services

Routine operating costs and ancillary charges associated with an approved transplant are carved out of the hospital's cost report. Reimbursement is limited to the lesser of cost or the hospital-specific per diem limitation for each type of transplant.

Cost is defined as the hospital-specific ratio of cost to charges from the base period multiplied by the covered charges for the specific transplant type.

Per diem limitation is calculated by deriving the hospital's per diem for the transplant type from the hospital's base period trended forward using the Medicare target rate percentage for PPS-exempt hospitals each year.

The base period is the cost reporting period for the hospital fiscal year ending September 30, 1983 through August 31, 1984 or the first cost report filed subsequently that contains costs for that type of transplant,

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Item 1 (cont'd.)

H. Hospital Intensive Neurological Rehabilitation Care Units

Effective for services on or after January 1, 1993, reimbursement for neurological rehabilitation services provided by a Hospital Intensive Neurological Rehabilitation Care (HINRC) unit within an acute care general hospital is available separately from other hospital services. Establishment of such a unit is optional. Reimbursement for HINRC units is all inclusive and is not in addition to the hospital rate.

Admissions for neurological rehabilitation services provided by an enrolled HINRC unit shall be carved out and handled separately as a subprovider. A separate provider number shall be assigned to differentiate admissions to these units and their related costs from other hospital admissions and costs. Separate cost centers must be established as costs related to exempt neurological units shall not be allowed in the cost settlement process applicable to other admissions. Reimbursement for inpatient services provided in these units shall be a prospective statewide per diem.

An interim rate is established using reported partial year cost report data from state fiscal year 92-93. The prospective per diem rate is established using the audited statewide weighted average cost per day for all costs associated with HINRC units, using cost reporting periods ending in state fiscal year 93-94 as a base period. All payments made utilizing the interim rate shall be retroactively adjusted to concur with the prospective rate. Rates for subsequent years will be updated annually effective January 1 of each year by increasing the previous year's prospective per diem rate by HCFA's target rate percentage of non-PPS (PPS exempt) hospitals/units for the current federal fiscal year. The subsequent application

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of the inflationary adjustment shall apply only in years when the state legislature allocates funds for this purpose. The inflationary adjustment shall be made by applying the inflation factor applicable to the current fiscal year to the most recently paid per diem rate.

New units enrolling will be paid the statewide prospective per diem rate in effect at the time of enrollment.

If a unit enrolls at a time other than the beginning date for the hospital's new fiscal year, partial-year cost reports shall be submitted by the hospital for the pre-HINRC time period, and by the hospital and the HINRC unit for the period from the enrollment date of the HINRC unit through the end of the hospital's fiscal year.

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42 CFR
Sec. 447
Subpart C

Medical and Remedial Care and Services
Item 1 (cont'd.)

II. Standards for payment

A. To be eligible for full participation in the Bureau's vendor payment plan, a hospital in Louisiana:

1. Shall be licensed by the Department of Health and Hospitals, Bureau of Health Services Financing, Health Standards Section; **and**

2. Shall have been approved and accepted by the Bureau as a participating hospital under Title XIX; **and**

3. Shall be eligible for certification for the Hospital Insurance Program, Medicare Title XVIII-A; **and**

4. Shall agree not to accept payment, except for collectible insurance, from any source other than this Bureau for services for which this Bureau pays.

B. To be eligible for reimbursement for inpatient psychiatric services (including substance abuse treatment) in an acute care general hospital:

1. The services must be provided in a Distinct Part Psychiatric Unit, **except** reimbursement to an acute care general hospital may be available when limited to emergency admissions which must be stabilized and transferred to an appropriate facility; **and**

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42 CFR Sec. 447
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2. The Distinct Part Psychiatric Unit shall be Medicare PPS exempt certified or, if in a Medicare PPS exempt hospital, meet PPS exempt psychiatric unit criteria as stated at 42 CFR 412.25 [except 412.25(a)(1)(ii)] and be certified by Medicaid only.

C. To be eligible for reimbursement for services provided by a **Hospital Intensive Neurological Rehabilitation Care (HINRC) unit**, a hospital must:

1. Meet the requirements of A. above;
   and
2. Be accredited by the Joint Commission of Accreditation of Healthcare Organizations (JCAHO) and by the Commission on Accreditation of Rehabilitation Facilities (CARF);
   and
3. Contain a unit that meets the requirements for a HINRC unit as described in Attachment 3.1-A, Item 1;
   and
4. Enroll the HINRC unit separately as a Medicaid provider of Hospital Intensive Neurological Rehabilitation Care.

D. To be eligible for reimbursement for services provided by a **major teaching hospital**, a hospital must:

1. Meet the requirements of A. above;
   and
2. Be enrolled with full membership in the Council of Teaching Hospitals (COTH);
   and
3. Be recognized by Medicare as a teaching hospital.

The following regulations are applicable:

Initial determination: The initial group of major teaching hospitals is comprised of hospitals that possessed these credentials as of December 31, 1992 as verified by COTH documentation submitted by the hospitals and verification of Medicare teaching status from the Medicare fiscal intermediary.

Loss of COTH Membership: Hospitals that are no longer members of COTH must notify the Institutional Reimbursement Section within 15 days of the date the hospital is notified that its membership has terminated. Hospitals will be placed into the appropriate peer group effective with the date of the change. Any resulting overpayment will be recouped.

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Loss of Medicare teaching status: The hospitals must report loss of Medicare teaching status to the Institutional Reimbursement Section within 15 days of notice from Medicare. Hospitals will be placed into the appropriate peer group effective with the date of the change. Any resulting overpayment will be recouped.

Newly obtained COTH membership: If a hospital obtains COTH status subsequent to December 31, 1992, the hospital must notify the Institutional Reimbursement Section regarding this change in status and submit documentation to demonstrate COTH status. The hospital will be eligible for consideration of placement into the major teaching hospital peer group at the beginning of the State's next fiscal year, provided notification is received by Institutional Reimbursement Section at least 90 days prior to the beginning of the State fiscal year.

E. To be eligible for reimbursement for services provided by a **minor teaching hospital,** a hospital must:

1. Meet the requirements of A. above;
   and
2. Be recognized by Medicare as a teaching hospital that does not meet the COTH requirements.

The following regulations are applicable:

Initial determination: Verification of Medicare teaching status from the Medicare fiscal intermediary was obtained initially by the Medicaid Agency.

Loss of Medicare teaching status: The hospitals must report loss of Medicare teaching status to the Institutional Reimbursement Section within 15 days of notice from Medicare. Hospitals will be placed into the appropriate peer group effective with the date of the change. Any resulting overpayment will be recouped.

Newly obtained Medicare teaching status: The hospital must report acquisition of Medicare teaching status to the Institutional Reimbursement Section at least 90 days prior to the beginning of the next State fiscal year to be eligible for consideration of placement into the minor teaching hospital peer group.

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F. To be eligible for reimbursement for services provided by a **specialty hospital,** a hospital must:

1. Meet the requirements of A. above;
and
2. Be recognized as a rehabilitation hospital, long-term (ventilator) hospital, or children's hospital recognized by Medicare as a PPS-exempt hospital. A specialty hospital is always classified in the appropriate specialty hospital peer group, irrespective of technical qualification to be included in any other peer group. The Medicaid Agency obtains verification from the Medicare fiscal intermediary of Medicare PPS-exempt status initially and annually thereafter prior to calculation of the next state fiscal year's rate.

The following regulations are applicable:

Loss of Medicare P.P.S.-exempt status: The hospital must report loss of Medicare P.P.S.-exempt status within 15 days of notice from Medicare. Hospitals will be placed into the appropriate peer group effective with the date of the change. Any resulting overpayment will be recouped.

Newly-obtained Medicare P.P.S.-exempt status: The hospital must report acquisition of Medicare P.P.S.-exempt status at least 90 days prior to the beginning of the State fiscal year to be eligible for consideration of placement into the appropriate specialty hospital peer group.

G. To be eligible for reimbursement for services provided by a **Burn Care Unit**, the unit must meet the following qualifications:

1. The hospital in which the unit is located must meet the requirements of A. above;
and
2. The unit must meet the criteria specified in the hospital services provider manual.

H. To be eligible for reimbursement for services provided by a **Neonatal Intensive Care (NICU) Unit**, the unit must meet the following qualifications:

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